



# Registration Form

1. First Name: \_\_\_\_\_ 2. Family Name: \_\_\_\_\_  
(Include maiden name if applicable)

3. Sex: Female Male 4. Date of Birth: \_\_\_/\_\_\_/\_\_\_ 5. Age: \_\_\_\_\_  
mm dd yyyy

6. Address: \_\_\_\_\_  
Apt # - Street and Number City Province Postal Code

7. Phone #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Home Work Cell

8. E-mail: \_\_\_\_\_  
(By writing my email address, I consent to receive emails from CHIP)

9. Occupation : \_\_\_\_\_

10. Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

11. Who referred you to CHIP? (MD, nurse, hospital, friend, flyer, poster...) \_\_\_\_\_

12. Name of Family MD: \_\_\_\_\_ Cardiologist: \_\_\_\_\_

Endocrinologist: \_\_\_\_\_ Other: \_\_\_\_\_

13. Has a doctor ever told you that you have **cardiovascular disease**  
(stroke, angina, heart attack, or coronary bypass surgery, angioplasty)? YES NO

14. Has anyone in your immediate family (parents, siblings) DON'T KNOW YES NO  
developed cardiovascular disease **before age 60**?

15. Does anyone in your immediate family (parents, siblings) DON'T KNOW YES NO  
have **diabetes**?

16. Do you currently **smoke** one or more cigarettes daily? YES NO

17. Please list current **medications, natural products, or supplements** and please include **dosage**:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. **Personal History** (Please check)

Heart condition \_\_\_\_\_  
High cholesterol \_\_\_\_\_  
**Diabetes or** \_\_\_\_\_  
**High Blood Sugar** \_\_\_\_\_  
Epilepsy \_\_\_\_\_  
Stroke \_\_\_\_\_

Bone or joint problems \_\_\_\_\_  
Varicose veins \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Injuries to back \_\_\_\_\_  
Gout \_\_\_\_\_  
Lung disease \_\_\_\_\_

**Please continue on back**





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19. **Present symptom review** (Have you recently had any of the following symptoms at rest, during exertion or after exertion?)

- |                          |       |                             |       |
|--------------------------|-------|-----------------------------|-------|
| Chest pain or discomfort | _____ | Lightheadedness or fainting | _____ |
| Back pain                | _____ | Shortness of breath         | _____ |
| Arthritis/swollen joints | _____ | Heart palpitations          | _____ |
| Recent Illness           | _____ | Cough on exertion           | _____ |
|                          |       | Other                       | _____ |

20. Do you have problems falling asleep, staying asleep, or waking earlier than planned?  YES  NO

21. Do you have difficulty with time management and prioritizing?  YES  NO

22. Are you experiencing difficulty managing your eating habits?  YES  NO

23. Do you have doubts about your ability to persist with an exercise program?  YES  NO

24. During the last 7 days, on how many days did you do moderate physical activities for a period of at least 10 minutes, such as brisk walking, carrying light loads, bicycling or swimming at a regular pace, doubles tennis, raking or picking up leaves, or sweeping floors?

\_\_\_\_\_ **days/week**

25. How much time did you usually spend doing moderate physical activities on one of those days?

\_\_\_\_\_ **minutes/day**

26. During the last 7 days, on how many days did you do vigorous physical activities for a period of at least 10 minutes, such as heavy lifting, digging, aerobics, fast bicycling or swimming, jogging, or playing soccer?

\_\_\_\_\_ **days/week**

27. How much time did you usually spend doing vigorous physical activities on one of those days?

\_\_\_\_\_ **minutes/day**

28. Do you have any orthopedic problems which could be worsened with exercise?

If yes, please explain: \_\_\_\_\_

29. Do you have private insurance, who is your provider? \_\_\_\_\_

**Participant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy